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State/Territory Name: Puerto Rico

State Plan Amendment (SPA) # 24-0003

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106
Medicaid and CHIP Operations Group

July 5, 2024

Dinorah Collazo
Medicaid Director
Department of Health
P.O. Box 70184
San Juan, PR 00936-8184

Re: Puerto Rico State Plan Amendment (SPA) 24-0003

Dear Medicaid Director Collazo,

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid Premium and Cost-Sharing State Plan Amendment (SPA) submitted to CMS on May 10, 2024, under transmittal 24-0003. This SPA proposes to update the territory's premiums and cost-sharing payment tracking process.

This letter informs you that Puerto Rico Medicaid SPA 24-0003 was approved on July 3, 2024, effective April 1, 2024. Enclosed are a copy of the approved state plan pages and CMS-179 form to be incorporated into Puerto Rico's state plan.

If you have any questions, please contact Ivelisse Salce at 212-616-2411 or via email at Ivelisse.Salce@cms.hhs.gov.

Sincerely,

[redacted]

Falecia M. Smith, Acting Director
Division of Program Operations

cc: Debra Harris
Annie Hollis

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Puerto Rico**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1- to 4-character alpha/numeric suffix.

PR-24-0003

Proposed Effective Date

04/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

1916A of the Social Security Act and 42 CFR 447.56

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 0.00
Second Year	2025	$ 0.00

Subject of Amendment

Copay Tracking

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Designated to Medicaid Director

Signature of State Agency Official

Submitted By:	**Joselyn Drullard**
Last Revision Date:	**May 10, 2024**
Submit Date:	**May 10, 2024**

Medicaid Premiums and Cost Sharing

State Name: Puerto Rico

OMB Control Number: 0938-1148

Transmittal Number: PR - 24 - 0003

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. **Yes**

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. **No**

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

Compliance with AI/AN cost sharing exemption will be monitored by ASES.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☐ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☒ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

(1) Contracts between ASES and MCOs include the requirement to exempt populations and services defined in 42 CFR 447.56(a). MCOs produce the cards with indicators as required by contract to make these exemptions know to beneficiaries and providers.

(2) Compliance with cost sharing exemptions will be monitored by ASES.

(3) ASES requires that PBMs inform providers whether the copayment for a specific service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the copayment, as a condition for receiving the service, through an indicator: 1. In the Eligibility and Enrollment System; 2. On the Beneficiary Identification Card. 3. Contracts between ASES and MCOs (MAOs for Platino Plans) and providers shall include the Cost Sharing Policy.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

Since January 1, 2023, there have only been copays on prescription drugs and non-emergency use of the emergency room; therefore, the likelihood of a beneficiary reaching the cap is significantly reduced. Puerto Rico generates a report at least quarterly to show when a beneficiary reaches 95% of the aggregate limit of the quarterly cap (cap) and a territory worker exempts the beneficiary from copays until the end of their eligibility period. Puerto Rico will evaluate the effectiveness of this 95% of cap report and may change the percentage of the cap to ensure it is capturing all beneficiaries at risk of exceeding the cap.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

Written communication to the beneficiary includes an explanation of his/her right to appeal any decision and request a fair hearing.

■ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

There may be instances when the 95% of cap report may not identify a beneficiary prior to them exceeding the cap. For these instances, Puerto Rico generates a report at least quarterly that shows beneficiaries that have reached 100% of the cap. For cases where an excess cost-sharing amount has been incurred, a reimbursement amount will be calculated. A written explanation will be sent to the beneficiary. The written communication to the beneficiary will include an explanation of his/her right to appeal any decision and request a fair hearing.
Additionally, a beneficiary may request reimbursement when he/she understands that his/her aggregate limit for cost-sharing has been exceeded in a quarter, even if they do not appear on a report.

Reimbursement requests will be investigated to validate the beneficiary's eligibility and aggregate limit for the quarter. For validated requests, all service claims for the beneficiary's family in the quarter will be examined and the aggregate, incurred cost-sharing amount calculated and then compared to the aggregate cost-sharing limit for the beneficiary. For cases in which an excess cost-sharing amount has been incurred, a reimbursement amount will be calculated. A written explanation will be sent to the beneficiary with the results of the investigation.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Any beneficiary who notifies the Medicaid Program of a change in circumstances will be re-evaluated and the family aggregate limit will be re-calculated as an inherent part of the re-evaluation process. No beneficiaries are subject to premiums.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

V.20160722